Health Information Technology Policy Committee
Final Summary
October 20, 2010, Meeting

KEY TOPICS

1. Call to Order

Judy Sparrow, Office of the National Coordinator (ONC), welcomed participants to the 17th meeting of the Health Information Technology Policy Committee (HITPC). She reminded the group that this was a Federal Advisory Committee meeting, and was being conducted with the opportunity for public comment. She conducted roll call, and turned the meeting over to National Coordinator for Health Information Technology David Blumenthal.

2. Opening Remarks

David Blumenthal noted that this meeting marks the start of the next phase in the work of the ONC, the administration, and this group. The Committee will discuss the next stages of meaningful use—he assured those who are involved in trying to react to the first stage of meaningful use that the ONC is not already changing its parameters for Stages 2 and 3. He acknowledged that the first stage was rushed, and the tight timeframe did not allow for a great deal of reflection or careful forward planning. There is an opportunity to improve the process and give more careful consideration to longer-term strategies for the next meaningful use stages.

One issue to be considered is how to keep moving forward on a health information exchange (HIE) infrastructure. Stage 1 focused mostly on adoption and use within health care operations. Later stages of meaningful use will be more concerned with information exchange. Related to this, the Privacy and Security Tiger Team must continue to work on protecting information at rest and in transit so that the public has confidence and trust in the health system's ability to steward their health information capably.

Tony Trenkle of the Centers for Medicare and Medicaid Services (CMS) Tony Trenkle noted that there are a few relevant documents that are now in the clearance process. One is corrections notice that will address some regulation errors. The other is a detailed set of objectives that that are expected to be posted on the CMS Web site in the near future. A set of frequently asked questions has been posted online and are being revised so as to be easier to sort. CMS also is working with the ONC to develop a joint presentation for the public.

3. Review of the Agenda

HITPC Vice Chair Paul Tang reviewed the day's agenda.

4. Meaningful Use: Discussion on Strategy/Stage 2/3 Meaningful Use Criteria

George Hripcsak, Meaningful Use Workgroup Co-Chair, recapped the highlights of the Stage 1 recommendation process and outlined the hearings and other work that the group has carried out towards developing recommendations for meaningful use Stages 1 and 3. He presented a series of slides to spur Committee discussion about philosophical approaches the Workgroup might take for Stages 2 and 3. Topics included: (1) the positioning of Stage 2, (2) migration to outcomes, (3) patient engagement information sharing, and (4) external criteria. In discussing the positioning of Stage 2, George Hripcsak explained that it could be seen as an incremental change over Stage 1 (which has the advantage of extending current implementation plans but the disadvantage of continuing the uncertainty for the market in terms of Stage 3. The positioning of Stage 2 also could be seen as a stepping stone to Stage 3 (carrying with it the advantage of establishing a roadmap and timeline).

Before moving on to the next part of the presentation, the floor was opened for discussion among Committee members.

- Paul Egerman noted that Stage 2 must address everything that was signaled in Stage 1 in order for people to trust the overall roadmap. George Hripcsak confirmed that the Workgroup examined all of the placeholders from the original roadmap created during Stage 1 as it developed its list of items to address.

- Paul Egerman also suggested that privacy and security should be emphasized in Stage 2, because advancement in those areas does not require a significant amount of training and workflow changes on the part of clinicians.

- One Committee member commented on the incremental change versus stepping stone approaches, noting that the two are not necessarily mutually exclusive. HITPC members have heard clearly from providers that they want to know where Stage 3 is heading, and statements in this regard would be received positively. It is important to be able to make course corrections during the process, and establishing an overall goal would be helpful.

- In response to a question by Judy Faulkner, Tony Trenkle explained that CMS is still considering dates for rulemaking. George Hripcsak anticipated that timelines would be similar to those set for Stage 1. A Notice of Proposed Rulemaking (NPRM) for 2010 would be released in January 2012 if the same timeframes are used. The timing is partly determined by the NPRM process and also reflects a desire to obtain feedback from the previous stage before moving to the next. It is recognized that vendors want as much notice as possible, so efforts are being made to balance these issues.

- Judy Faulkner indicated that it appears that hospitals will have to implement in January of 2013, 6 months earlier than the timeline from Stage 1. That is a very short window of time, and will cause a crunch. In comparing the deadlines for Stages 1 and 2, David Blumenthal indicated that there are 6 additional months for Stage 2.

- Judy Faulkner pointed out that there are differences between the proposed rule and the final rule. When the details for Stage 1 were released, there were changes that caused thousands

of hours of work. She offered smoking rules as an example. Sometimes people may not understand how much programming it takes to make the modifications that were necessary.

- LaTanya Sweeney strongly encouraged the inclusion of IDC incentives in meaningful use criteria. She also noted that the penalties for privacy and security breaches are outlined in the Health Insurance Portability and Accountability Act (HIPAA), and that the Health Information Technology for Economic and Clinical Health Act (HITECH) specifically indicate that HIPAA is not sufficient.

- Judy Faulkner suggested moving the scope of the timing discussion from a position of "it could be hard for vendors to get their work done" to one of "the pace of this change could endanger patient safety."

- David Blumenthal urged the Committee not to curtail their visions based on feeling anxious about the timeframe.

George Hripcsak then directed the conversation to outcomes. Potential areas of focus for the Meaningful Use Workgroup include: (1) set Stage 3 outcomes-based measures; (2) directly measure the benefits of HIT; (3) satisfy process measures by achieving a threshold performance measure; (4) support value-based purchasing (to reduce dependence on process measures); (5) reduce the emphasis on the "how," in favor of the "what," to promote innovation; (6) reduce the burden of measuring structure and process, and (7) introduce outcomes orientation in Stage 2.

Instead of being precise as to the functions of the system in looking towards Stage 3, he asked Committee members whether the system should reward provider organizations for outcomes. David Blumenthal commented that the Beacon Community Program operates in this way, specifying outcome goals and not IT goals.

In Committee discussion of this topic, the following points were made:

- David Bates indicated that the notion of getting to outcomes by 2015 is very challenging. Measureable outcomes do not yet exist for many domains, and those measures take time to develop. He noted that in the United Kingdom, there is an elaborate framework that includes very little on outcomes, because they have not been able to align items properly to make it reasonable to measure in this way. He suggested that the system should include paying for processes associated with outcomes.

- Judy Faulkner expressed the need for caution with regard to testing, because some organizations are already excelling in this area. Demanding a certain percentage increase in a particular measure would not be sensible; instead, these organizations should be asked to meet an absolute. Other groups, however, may not be able to meet an absolute, because they are dealing with a more challenging population. She recommended offering both ways as an option (i.e., either attain a certain measure or a percentage).

- Gayle Harrell noted that the Workgroup needs to address who sets the outcomes that are being discussed. Is there a general consensus as to what the outcomes should be? Will each

different specialty group set those outcomes? Neither the Committee nor the ONC are likely to have the necessary expertise to set those parameters.

- Neil Calman voiced concern about the sustainability of the change. The capability of the systems used creates sustainable change. The next generation of doctors will have these new methods and tools. He explained that sustainability comes with building systems with functionalities that become part of the tools that are used every day. He also suggested that the Workgroup consider delta measures—that is, measures that look for a 10% reduction in something, for example. In order to consider delta measures without manual process or historical information, it is necessary to put a system in place and then wait until it is possible to obtain a baseline measure. He indicated that he is not very enthusiastic about this concept because it could stall the start of improvement processes if measures are tied to percentage improvements.

- Paul Egerman suggested that as part of Stage 3, transparency of outcomes measures be included. The act of publishing outcomes is in itself an incentive for improvement. However, he did acknowledge that it probably does not make sense to reward organizations for publishing a rate of zero.

- Christine Bechtel suggested that the patient experience survey would be one way of measuring experiences and outcomes. This could be HIT-enabled, but it would be a different kind of enablement. If Congress asked for measuring and improving overall health outcomes, then patient assessments are very useful tools.

George Hripcsak then continued his presentation with a discussion of patient engagement and information-sharing issues. Topics for Workgroup consideration include: (1) moving towards innovative use of patient data; (2) clearly defining terminology (e.g., "access" vs. "copy" vs. "clinical summaries" vs. "discharge instructions"); (3) setting differences and information purposes; (4) discharge instructions for hospitals; and (5) visit summaries for ambulatory care.

The following points were made in the Committee's discussion of this section:

- LaTanya Sweeney explained that to empower patients, they must be able to access and copy their information, because that allows them to move the data and do things with it. A patient may have 20 different portals to access, and that is not reasonable. But, if they could acquire their information and move it among repositories, that would give them some power.

- David Lansky emphasized the need to reinforce the idea that every EHR is just a node in the network, or a feeder into a larger system. He expressed hope that the data are viewed as being fluid and being in service of multiple applications.

- Gayle Harrell suggested that this is the point at which personal health care records (PHRs) come into the discussion, because they empower patients and are personal records from which all portals could get their information.

Next, George Hripcsak presented information to help the Committee explore deeming of external certification. He suggested using external certification to deem satisfaction of specific meaningful use criteria. One hypothetical example is the question of whether satisfaction of meaningful use care-coordination criteria satisfies the HIT component of patient-centered medical homes, or is PCMH accreditation deemed to satisfy care coordination criteria. Another hypothetical example is the question of whether satisfying meaningful use category 1 criteria (quality, safety, efficiency) satisfies the HIT component of professional maintenance of certification (MOC) for medical boards or whether MOC is deemed to satisfy a subset of meaningful use criteria?

Committee discussion included these points:

- David Blumenthal suggested outlining a separate track for those who are already rising above the standards that meaningful use has set. Gayle Harrell commented that, if the Committee has the statutory authority to address this issue, it opens up a new area for exploration. External groups and specialty societies could represent paths by which specialty measures could be addressed. If there is a way to decentralize and allow some of the specialty groups to develop criteria, it would significantly open up the process.

- It was suggested that there is a need to examine the criteria and determine what is missing— particularly on the specialty side—that makes it difficult for people to meet the criteria for medical home with current EHRs.

- Paul Egerman noted that if separate classes of meaningful use are established, it will be important to avoid an economic separation of classes. Economically challenged institutions must be able to participate. He also urged that the criteria for meaningful use be as clear and objective as possible. If the process is going to be simplified and made more results oriented, it should be done in a way that does not require subjectivity or outside experts to determine whether a provider has succeeded.

5. Quality Measures Workgroup: Prioritized Measurement Concepts

Quality Measures Workgroup Co-Chair David Lansky reported that the group has created six tiger teams. The Workgroup will discuss patient engagement measures. David Lansky asked whether the Committee was comfortable with a discussion of assessing HIT using other sources of measurement. He noted that no individual EHR is suited to address everything about care coordination. What structure will they use to get information that is outside of EHRs? Also, CMS has put forward the model of core measures and menu measures. The Quality Measures Workgroup will consider whether that is a sustainable framework.

David Lansky then presented information about the six tiger teams, noting that one of the teams has not yet met and that the Workgroup has not yet received formal reports from any of the teams. He explained that the Care Coordination Tiger Team has identified four priority sub-domains on which to focus their efforts:

- Effective care plans. An effective care plan is a partnership between the patient, his/her

family, and the health care team. This also may be known as a self management plan.

- Care transitions. A care transition is the movement of a patient between health care providers or health care settings. A care transition occurs any time there is a patient handoff.

- Appropriate and timely follow-up. Appropriate and timely follow-up includes the response from the recipient (physician), such as taking a follow-up action, and acknowledgment of the receipt of the information to the patient and/or sender (specialty provider, etc.).

- Intervention coordination. Intervention coordination includes medication management and intervention management, such as diagnostic imaging, testing and other services. Coordination should be appropriate, affordable, and be communicated to the patient.

The Workgroup's Care Coordination Tiger Team began to formulate measurement concepts to measure areas in these sub-domains, with the goal of identifying high-level domains of care, sub-domains, and measures. David Lansky presented a slide outlining care coordination sub-domains and measures, efficiency (including underuse and overuse), patient safety, patient and family engagement, population, and public health.

The discussion that followed included the following highlights:

- LaTanya Sweeney suggested adding privacy and information exchange to the Workgroup's topics of study.

- Gayle Harrell suggested that the measures be specialty-independent, and broad enough that most providers would have the ability to qualify. Also, she suggested a minimal number of measures, and hoped that those measures are not overly burdensome to get into the records.

- Paul Tang indicated that it appears as though many of these measure concepts are more structural than previously envisioned. One approach for the Patient Engagement Tiger Team would be to rely more on the patient input for measurement.

- LaTanya Sweeney suggested that the issues considered here are not ones that meaningful use or the Privacy and Security Tiger Team would address. She sees this as a very attractive way to obtain a large number of data measures. Privacy should be included in the quality measures, just as patient engagement and other factors should be included.

- Christine Bechtel commented that although the necessary expertise may not be available on the Patient and Family Engagement Tiger Team, it may be helpful to consider the role that technology plays in patient engagement and trust.

Following these comments and before proceeding with the agenda, Paul Tang asked for and received approval from the last HITPC meeting (held on September 14, 2010).

> **Action Item #1:** Minutes from the September 14, 2010, HITPC meeting were approved by consensus.

6. Information Exchange Workgroup: Provider Directories Recommendations on Key Principles

Information Exchange Workgroup Chair Micky Tripathi noted that at the November HITPC meeting, this group will offer a round of initial recommendations focused on what are being termed "entity-level" directory services. A second round of recommendations, presented to the Committee at a subsequent meeting, will focus on best practices recommendations for states, regions, and other sub-national players interested in developing broader discoverability resources.

The Information Exchange Workgroup has established a Provider Directory Task Force. Micky Tripathi explained that HIE, with a sender conveying an unsolicited communication to a known recipient, occurs today with high frequency through a variety of channels, including fax, phone, and mail as well as through electronic networks. Directories perform a key function in any of these transactions, because they map human information to machine-readable information. Currently, most directories are proprietary and specific to a particular mode of exchange. The most well-known non-proprietary cross-organizational directory is the distributed DNS registry system that is used for Internet routing.

Directed exchange transactions will continue to grow whether or not government action is taken on provider directories, because these directories automate things and make them more scalable in business exchanges. However, the rate of adoption will almost certainly be hindered if there is not a uniform and ubiquitous approach to cross-platform exchange. Provider directories can play a key role in these activities.

The Information Exchange Workgroup held a public hearing on September 30, 2010, that included four panels, with two of the panels focused on business requirements. At the hearing, there was discussion on the business requirements that already exist, state and regional issues, and technical requirements. Some of the common themes/needs that arose from the hearing include: (1) distinguishing between an entity-level versus a clinician-level directory; (2) supporting interoperability across states and regions; (3) aligning meaningful use Stage 1 transaction needs, with the flexibility necessary for Stages 2 and 3; and (4) awareness of the role and the needs of the Nationwide Health Information Network Direct.

Entity-level directories should be the first priority, Micky Tripathi explained. At this level, they must find a standard-addressing scheme and they must establish basic discoverability of an entity and of its security credentials. These entity-level directories should be defined with what the Workgroup is terming "rigid conformance" at the national level. At the clinician level, this would all be important as well, but it is likely to be much more complex. Development and implementation can be more flexible at a sub-national, regional, or state level, because the information is easier to consider on a more localized level.

The policy objective is to facilitate the rapid increase and secure electronic HIE throughout the health system. The Workgroup wants to assist in whatever ways possible to accelerate what is

going to happen, but acknowledges that industry does not need state or federal action on provider directories in order to proceed with them.

Micky Tripathi indicated that there are a number of issues that could benefit from Workgroup recommendations. For example, the lack of a consistent approach to cross-organizational provider directories will be a barrier, both in terms of directed exchange and in HIE more broadly. Also, without any action on the part of the Committee/ONC, an opportunity to align multiple activities and common streams of funding that could yield a lower cost and a higher quality of service will almost certainly be missed.

Micky Tripathi explained that priority should be given to provider directories that facilitate meaningful use Stage 1 transactions. The sender of a message must know what kind of messages the recipient is able to consume, and what mode of communication they should use. How does one identify both the correct recipient and their address for a given mode? Security is another component—the sender needs to verify that the recipient computer has appropriate security credentials. Transport also needs to be considered (there must be a secure means of transporting the message, and there are multiple possibilities for doing so).

The Workgroup has divided high-level principles into two categories. First, those initial principles that might apply to provider directories across the board. Second, those initial principles that should apply to the Workgroup's provider directory recommendations.

In moving forward, Micky Tripathi explained that the recommendations developed by the Provider Directory Task Force and the Information Exchange Workgroup need to be agile and responsive to current and future needs, and flexible to changes that occur in health reform, technology, and business organization. The recommendations should be incremental, actionable and achievable, and build a roadmap, but have some near-term steps that can be taken to solve problems in the near term.

Committee discussion included these points:

- Micky Tripathi confirmed that the Workgroup plans to create a roadmap to directories so that interoperability in a clinician's role is possible, given that so much of the care in this country is delivered in practices of 10 providers or fewer. The definition of "entity" is critical in this context, and the Workgroup is considering it as an addressable node on the network. Paul Egerman added that entities also include laboratories, retail pharmacies, commercial clearinghouses, and others.

- LaTanya Sweeney noted that in a study exploring information exchange, researchers examined provider directories and discovered that the question of whether an entity is a group or a provider is a nontrivial issue. For example, a provider might be in the directory under their identity; they may be operating in multiple hospitals; and also a part of a practice. That same provider would have five different identities as one person. She also suggested moving away from trying to push security and authentication into the provider directory and leaving them independent, primarily because of variations in state laws.

- It was noted that when there is a one-person practice, that clinician becomes an entity at that point.

- Larry Wolf pointed out that, in the example of delivery, the message needs to get to the organization and then to the patient. Micky Tripathi agreed, explaining that patient identity management is a major component of this effort. He expressed the need to avoid derailing efforts to get the organizational directories working, but added that there also is a need to deliver information to the patient.

- Jim Borland commented that the challenge is not in identifying the location of a provider, but identifying the location of a patient's records. That points to the situation in which a clinician leaves an entity and leaves a patient's records behind. This can be viewed as a data repository identification problem.

- Deven McGraw asked whether participation in the directory is voluntary, and if so, what must be in place to encourage providers to participate in these directories? Who gets to access these directories? They could be very valuable for more than just the exchange that is being discussed at this meeting.

- In response to a question by LaTanya Sweeney, Micky Tripathi acknowledged the danger of presenting a particular two-dimensional representation of how the exchange might work. There is not yet a particular way of illustrating the exchange; he was trying to characterize what systems look like today and what the problems are that they might encounter. LaTanya Sweeney pointed out that there are many companies who are willing to put money on the table to create data exchange. Micky Tripathi emphasized that the Workgroup is not wedded to any particular concept.

7. Privacy and Security Tiger Team Recommendations on Transparency

Privacy and Security Tiger Team Chair Deven McGraw reminded the Committee that the Tiger Team is helping to create a comprehensive privacy and security policy framework that can govern HIE moving forward. He provided an update on an initial set of recommendations on the principle of openness and transparency. The Tiger Team provided Committee members with a complete set of documentation on these recommendations, and just presented some of the major points at this Committee meeting. Tiger Team Co-Chair Paul Egerman presented the group's core values, including a new core value:

> Transparency about information exchange practices is a necessary component of establishing credibility with patients. In achieving greater openness and transparency for patients, we need to balance the need to give patients complete information on how their information is shared while at the same time providing information in a form that is manageable for patients to read and understand.

Deven McGraw explained that the solution to the transparency problem is found in a layered approach. Together with Paul Egerman, they presented the Team's recommendations on transparency, as follows:

- Providers should provide the HIPAA Notice of Privacy Protection (NPP) as a layered notice. This should include: (1) a short summary of sharing policies and activities; (2) a detailed notice for interested patients; (3) text in plain English and at an appropriate reading level; and (4) current and anticipated exchange activities, not just what the law permits

- The ONC should require federally funded health information organizations (HIOs) and regional extension centers (RECs) to develop and implement public education plans regarding their information sharing policies and practices.

- The Tiger Team also developed examples of summary notices for situations in which HIOs and Organized Health Care Arrangements (OHCAs) are involved.

The Tiger Team produced a number of sample notices, several of which were included in Committee members' handouts.

A discussion followed and included these points:

- Jim Borland suggested that the group look at the issue of electronic notice. An explicit recommendation to allow electronic consent authorization notice would send a signal to both the privacy and security community as well as the vendor community to explicitly allow electronic consent authorization notice rather than just imply it.

- Neil Calman reviewed the example privacy notice, which indicates that the provider is going to make a patient's data available to other health care professionals. The notice does not indicate what these other health care professionals will do with the data. He indicated that this omission negates the value of the notice. Deven McGraw indicated that the privacy notice is important from a transparency standpoint, but it is in no way sufficient. There should be some very clear standards that have to be met and involved parties must be held accountable with respect to how they share data.

- Further to his earlier point, Neil Calman indicated that patients need to be told where to go to find a fuller picture of what is happening with their data. LaTanya Sweeney suggested using audit trails as a tool to help people know what is happening with their information.

- Deven McGraw suggested that this could be characterized as an initial set of recommendations on transparency that is not sufficient, and the Committee could take all of these into consideration where it continues to build on its work on transparency.

8. Governance Workgroup: Governance Mechanisms for HIE

Governance Workgroup Chair John Lumpkin reported that since the last HITPC meeting, the Governance Workgroup has gone through the process of considering what governance looks like and what things are covered by governance. They wanted to address the "what" before they started to consider the "who." Governance is essential to make decisions needed to accomplish the HIT agenda and the goals of HITECH. It is necessary for the existing limited exchange to

expand and grow beyond those entities under federal context, grant, or corroborative agreement. It is also needed to validate and assure that conditions for trust in a nationwide interoperability exists. In addition, governance must be in place for transparent oversight enforcement in accountability.

John Lumpkin discussed areas of current focus for the Workgroup and shared the Workgroup's timeline, which indicates that the group will come back before this Committee in November with final recommendations. The Governance Workgroup's principles of guidance are as follows:

- Recognize and leverage existing governance mechanisms where feasible for the Nationwide Health Information Network (NW-HIN).

- Identify and bridge gaps in existing governance mechanisms for the NW-HIN.

- Identify those aspects of NW-HIN governance (existing and new) where national-level coordination could enhance and/or promote greater trust and interoperability, and suggest approaches for appropriate coordination.

- Assure maximum flexibility for evolution and innovation; avoid rigid rulemaking.

- Address barriers and promote exchange of health information through the NW-HIN.

John Lumpkin then presented nine sound principles for NW-HIN governance: (1) transparency and openness; (2) inclusive participation and adequate representation; (3) effectiveness and efficiency; (4) accountability; (5) federated governance and devolution; (6) clarity of mission and consistency of actions; (7) fairness and due process; (8) promote and support innovation; and (9) evaluation, learning and continuous improvement. With these principles in mind, he presented some general Workgroup recommendations:

- The ONC should establish a national framework for governance of the NW-HIN that reflects "governance of governances" based on the nine sound governance principles.

- Governance of the NW-HIN should include a core set of functions, with national-level coordination and oversight across those functions.

- Governance of the NW-HIN should include opportunities for broad stakeholder input, including consumers, on the strategic direction for the NW-HIN.

He also recommended core functions that identify the types of governance decisions that need to be addressed for the NW-HIN. These include: (1) establish policies for privacy, security, interoperability, and to promote adoption of the NW-HIN; (2) establish technical requirements to assure policy and technical interoperability; (3) establish appropriate mechanisms to assure compliance, accountability, and enforcement; and (4) provide oversight of the governance mechanisms.

As part of its next steps, the Governance Workgroup will start to explore the issue of who will govern and the role of the ONC. Committee input on these topics was encouraged.

In discussion, the following points were made:

- In response to a question by LaTanya Sweeney, John Lumpkin explained that governance must operate in a way that is fair to those who participate in governance processes and those who are affected by governance decisions.

- John Lumpkin indicated that the Workgroup is looking at the NW-HIN as a seal of approval.

- Deven McGraw asked about the role of the ONC in governance and suggested that as the Workgroup and Committee consider the appropriate role of government, they broaden the lens to include such other entities as the Office of Civil Rights, CMS, and others.

8. Public Comment

- Carol Bickford from the American Nurses Association commented that she was struck by two items in relation to the patient engagement information sharing slide in the Privacy and Security Tiger Team report. One is, where is there a mechanism for incorporating the health care plan? The discussion included discharge instructions, visit summaries, the clinical data of repository, etc. She also noted that there is no mechanism for encompassing an identification of the team, or any recognition of that communication, that partnering, that inclusion of the patient.

- Shelly Spiro, Director of the Pharmacy e-HIT Collaborative, first she addressed the HITPC as a whole and explained that the Pharmacy e-HIT Collaborative is a newly formed group of nine professional pharmacy associations, representing more than 250,000 members, working in all different practice settings. The pharmacist's EHR has been developed and has been validated through both the National Council for Prescription Drug Programs and HL7. Soon, it will be going through the certification process. The Collaborative stands ready and willing to assist the HITPC in helping with the bi-directional exchange of clinical information outside of the prescription process.

- Tom Leary, Director of the Healthcare Information and Management System Society (HIMSS) thanked David Blumenthal for his comments suggesting that the HITPC collaborate with other activities within the Department of Health and Human Services. He referred specifically to the national health care quality strategy and plan effort that is currently underway. The collaboration will improve the possibility of HIMSS members meeting the requirements and the metrics that will be identified. He also recommended that the Committee work closely with the National Priorities Partnership convened by the National Quality Forum.

- Lindsay Hoggle, a private consultant speaking on behalf of the American Dietetic Association, referred to the discussion that took place following the Quality Measures Workgroup presentation. She suggested taking the existing quality measures and increasing

the percentages, thus allowing providers a time during Stage 2 to have a greater focus on consumer engagement. This might also encourage other providers to adopt EHRs with the realization that they have a moment to pause, make changes, carry out some risk analyses and risk mitigation, particularly with the timeline that they have in terms of vendor design and development. There is some concern about this large workflow change for everyone, including consumers. Consumers are not used to having all of their data in front of them. If they do receive it electronically, they may not know what to do with it.

- A caller from the American Hospital Association noted that the important themes he heard during the meeting were a commitment to evaluate and learn from early experiences on the ground. He heard recognition of the need for a realistic timeline, and the need for an approach that allows providers to use the power of EHRs to meet local needs. He also heard a commitment to put this work in a broader context of those existing regulations and changes that are coming with health reform. Today, more than 98% of hospitals report 40 or more quality measures to CMS on a quarterly basis. Those are all publicly available on the Hospital Compare Web site. Quality reporting is not new for hospitals. He noted the importance of data collection results being comparable from one provider to another; otherwise, providers will not want their quality results used because they will not think the process is fair. This is the context that the Committee needs to take forward into future quality-reporting efforts, which include a significant payment penalty for the 25% of hospitals with the highest readmission rate. The caller also noted the value-based purchasing program that will put a significant number of hospital payments at risk for actual performance on specific quality metrics that are being worked through by CMS. He wanted to make sure that the Workgroup is committed to paying a lot of attention to whether those measures are tested, validated, and pilot tested for operational use before they become part of the meaningful use requirements.

SUMMARY OF ACTION ITEMS:

Action Item #1: Minutes from the September 14, 2010, HITPC meeting were approved by consensus.